IN THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF FLORIDA
PENSACOLA DIVISION

RUSSELL T. NEAL,

Plaintiff,

vs. Case No.: 3:06cv17/MCR/EMT

OFFICER BOLTON and
DOCTOR HART,

Defendants.
_____/

DEFENDANT PAUL HART'S SPECIAL REPORT

Defendant Paul Hart provides the following information, defenses, and arguments in accordance with this Court's Orders entered August 6, 2007 (Doc. 32) and January 23, 2008 (Doc. 50).

Defendant Paul Hart respectfully requests dismissal of Plaintiff's claims for the reasons stated below. Alternatively, Defendant Paul Hart requests that summary judgment be entered in his favor.

Defendant Paul Hart further requests leave of Court to supplement this Special Report once all of Plaintiff's medical records are obtained from his providers. In order to avoid duplication of requests for medical records, Defendant Hart has requested co-defendant Bolton provide him with copies of any and all medical records requested and received on plaintiff. Defendant Bolton has provided medical records received to date; however, it is this

Defendant's understanding that the entirely of the records requested have not been received. Accordingly, this Defendant, Paul Hart, requests leave of Court to supplement his defenses as may be necessary upon receipt of additional medical records.

I. Background

Plaintiff, proceeding *pro se* and *in forma pauperis* (Doc. 1, 10, 12, 20, 22), has filed a Fourth Amended Civil Rights Complaint pursuant to 42 U.S.C. § 1983 (Doc. 22). The Plaintiff has not exhausted his administrative remedies with respect to his denial of medical care claim against Paul Hart and dismissal is warranted. Alternatively, summary judgment is also appropriate because Paul Hart is not a proper defendant and because Plaintiff's medical records do not show that his alleged injury is connected with any alleged conduct by Paul Hart.

Plaintiff is a state inmate currently incarcerated at the Calhoun Correctional Institution in Blountstown, Florida (Doc. 22). His Fourth Amended Complaint addresses incidents alleged to have occurred at the Okaloosa County Detention Center ("Okaloosa County Jail" or "OCJ"). (Id.) There are two defendants, Officer Bolton and Dr. Hart (Id. at 2).

Plaintiff alleges he was incarcerated at OCJ from April 30, 2003 through January 28, 2004, and again in 2005. He had several pre-diagnosed medical problems prior to being incarcerated including eye, back, neck, and shoulder problems. He informed medical and correctional staff of his medical needs and related physical limitations, including a diagnosis of glaucoma made on or about

August 2002 by Dr. Shawn Hamilton of the Hamilton Eye Institute in Crestview, Florida. Plaintiff indicated he needed surgery on his right eye and provided information on prescription medications he needed – "Cosupt and Pilocarpine". (Id. at ¶ 8). Plaintiff also advised of all health care professionals he had treated with. Despite this notice, Plaintiff was deprived of medications including eye drops for glaucoma. (Id. at ¶ 10). In May 2003, Plaintiff informed Defendant Hart that OCJ did not have the proper equipment to treat his glaucoma and that he needed surgery on his right eye (Id. at ¶¶11-12). Dr. Hart assured Plaintiff he would receive required eye medication (Id. at ¶¶ 13-14). From May 4, 2003, through September 1, 2003, Plaintiff complained to every shift during sick call that he needed medication for his eye (Id. at ¶ 15). Plaintiff received no eye medication from April 30, 2003, into August 2003 – a period of over one-hundred (100) days (Id. at ¶¶ 18-19). Plaintiff experienced excruciating and debilitating pain, and grieved of pain, fear of blindness, and lack of care and concern by staff (Id. at ¶¶19-20). Plaintiff complained that he needed specialized medical care as well as prescription lenses and eye surgery (Id. at ¶¶ 21-23). Plaintiff's glasses were seized upon his arrest and they were not returned until approximately August 24, 2004 (Id. at ¶ 23). By Plaintiff's account, the damage had already been done to his eye by this time (Id.). Before having his glasses returned, Plaintiff procured other prescription lenses of improper prescription (Id. at ¶ 24).

Plaintiff was provided ice packs to relieve the pain in his right eye caused by deprivation of glaucoma medications, but this was ineffective (Id. at ¶ 25). Plaintiff informed staff of his rapid visual loss and pain on a daily basis, which was recorded by nurses in Plaintiff's medical records (Id. at ¶ 26). Plaintiff was taken to the Hamilton Eye Institute on or about August 26, 2003, and a prescription for corrective lenses and eye medication was written; but neither the prescription lenses nor the eye medication were immediately provided to Plaintiff (Id. at ¶ 27). Plaintiff eventually received the new corrective lenses, but had to file a grievance to receive the medication even though staff knew how much pain Plaintiff was in (Id. at ¶ 28). In the interim, Plaintiff's criminal defense attorney, Michael D. Weinstock, retrieved an old bottle of eye medication from Plaintiff's home and brought it to OCJ, but it was lost by OCJ staff and only located after more grievances were filed by Plaintiff (Id. at ¶¶ 29-30). It was approximately one-hundred and twenty (120) days before Plaintiff was able to treat with his eye care specialist and/or receive any drops/eye medication (Id. at ¶ 31).

During his incarceration at OCJ, Plaintiff was also illuminated by a hand-held laser beam used by OCJ staff for entertainment (Id. at ¶ 32). Officer Auford threatened Plaintiff that he would target such a laser in Plaintiff's eye. Plaintiff asserts, and defendant Bolton disputes, that Officer Bolton shot a hand-held laser targeting device across Plaintiff's upper body while the Plaintiff was drying himself in the shower area of "E" Pod (Id. at ¶ 34). The laser beam burned a

"cheerio shaped" sore upon the center of Plaintiff's retina (Id. at ¶ 36). Scar tissue formed on Plaintiff's retina, but maintained the "cheerio shape" associated with damage produced by a laser (Id. at ¶¶ 37-38).

Plaintiff's medical condition upon leaving OCJ in January 2004 may be disputed upon receipt of Plaintiff's medical records from numerous medical providers. This may form the basis of an argument on summary judgment that natural degeneration is the cause of Plaintiff's eye problems and not anything having to do with the action or inaction of medical staff at OCJ. By Plaintiff's account, upon leaving OCJ on or about January 28, 2004, he could no longer see the eye chart without looking away from the chart and using his peripheral vision (Id. at ¶ 39). The first eye doctor to see the burn on Plaitniff's retina was Dr. Tugwell at Walton CI, who observed the burn when conducting an inner ocular examination (Id. at ¶ 40). "No other macular degeneration was present" (Id.). Dr. Tugwell referred Plaintiff to a retina specialist Dr. Schlofman, who examined Plaintiff's retina and declared it to be "shot out" (Id. at ¶¶ 40-41).

Plaintiff was later examined by Dr. Romchuk, but in the interim was beaten by officers at Walton CI during which Plaintiff's optical nerve became detached (Id. at ¶ 43). Plaintiff's retina was found to be inoperable, and the burn to Plaintiff's retina is permanent and irreversible (Id. at ¶¶ 43-44). Plaintiff's loss of his center field of vision directly relates to his retina being burned by being shot in the eye with a hand-held laser targeting device by Officer Bolton (Id. at ¶¶ 45, 51).

The withholding of eye medication and/or care, including the denial of prescribed lenses, causes an excessive increase to inner ocular pressure in a person with known glaucoma (Id. at ¶46). A person with glaucoma is compromised by enhanced conditions resulting from indifferent care (Id. at ¶ 48). Although a healthy eye is temporarily blinded by a laser targeting device, Plaintiff's glaucoma, which went untreated, made him susceptible to permanent injury form the laser (Id. at ¶¶ 47-50, 55). Dr. Hart was aware of plaintiff's diagnosed medical needs (Id. at ¶ 53). When Plaintiff returned to OCJ in January 2005, medical staff withheld his medications (Id. at ¶ 59).

Plaintiff claims that Dr. Hart denied prompt and necessary medical care in violation of the Eighth and Fourteenth Amendments (Id. at ¶¶ 61, 64-66, p. 34). Plaintiff further claims that Officer Bolton used excessive force in violation of the Eighth Amendment (Id. at ¶¶ 62, 67-73, p. 34).

As relief, Plaintiff seeks compensatory and punitive monetary damages, as well as medical care, should treatment develop to address his condition, and an order banning use of lasers at OCJ (Id. at p. 34).

Defendant Paul Hart presents the information in this Special Report and respectfully requests dismissal of Plaintiff's claim that defendant denied prompt and necessary medical care, or alternatively summary judgment for the reasons stated below.

II. Special Report

A. Failure to exhaust administrative remedies

Plaintiff has failed to exhaust administrative remedies prior to making his excessive force claim against Paul Hart.

Title 42 U.S.C § 1987e provides in relevant part:

> 42 U.S.C. § 1987e Applicability of Administrative Remedies
>
> No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted

42 U.S.C. § 1987e (a). Thus, exhaustion of all available administrative remedies is mandatory, and is a pre-condition to suit. Porter v. Nussle, 534 U.S. 516, 122 S.Ct. 983, 988, 152 L.Ed.2d 12 (2002) (citing Booth v. Churner, 532 U.S. 731, 739, 121 S.Ct. 1819, 149 L.Ed.2d 958 (2001)). The purpose of this exhaustion requirement is to reduce the quantity and improve the quality of prisoner suits. Porter, 534 U.S. at 524.

The exhaustion requirement applies to all inmate suits about prison life, whether they involve general circumstances or particular episodes, and whether they allege excessive force of some other wrong. Porter, supra. Exhaustion is required whether Plaintiff seeks declaratory and injunctive relief, monetary damages, or both. Booth, 532 U.S. 731; see also, Zolicoffer v. Scott, 55 F.Supp.2d 1372, 1375 (N.D. Ga.1999), aff'd, 252 F.3d 440 (11th Cir.2001). The requirement is not subject to either waiver by a court or futility or inadequacy exceptions. See, Booth, 532 U.S. at 741 n. 6; McCarthy v. Madigan, 503 U.S.

140, 112 S.Ct. 1081, 117 L.Ed.2d 291 (1992) ("Where Congress specifically mandates, exhaustion is required."); Alexander v. Hawk, 159 F.3d 1321, 1325-26 (11th Cir. 1998). Based on the foregoing, this court must dismiss a claim if it determines that Plaintiff failed to exhaust his administrative remedies with respect to that claim prior to filing suit. Higginbottom v. Carter, 223 F.3d 1259, 1261 (11th Cir. 2000); Alexander, 159 F.3d at 1325-26.

The PLRA also "requires proper exhaustion." Woodford v. Ngo, 548 U.S. 81, 126 S.Ct. 2378, 165 L.Ed.2d 368 (2006). In order to properly exhaust his claims, a prisoner must "us[e] all steps" in the administrative process; he must also comply with any administrative "deadlines and other critical procedure rules" along the way. Id. (internal quotation omitted). If a prisoner fails to complete the administrative process or falls short of compliance with procedural rules governing prisoner grievances, he procedurally defaults his claims. Johnson v. Meadows, 418 F.3d 1152, 1159 (11th Cir.2005), cert. denied, 126 S.Ct. 2978, 165 L.Ed.2d 988 (2006). Thus, an untimely grievance does not satisfy the exhaustion requirement of the PLRA. Id. at 157.

Grievances submitted by Plaintiff do not show exhaustion

The Fourth Amended Complaint incorrectly asserts that the Plaintiff has exhausted the grievance procedure with respect to the alleged excessive force claim against Paul Hart. The Plaintiff attached two Okaloosa County Inmate Request Forms denoted as "grievance" against Dr. Hart, dated August 11, 2003, and August 14, 2003. (See, Exhibit C attached hereto). Plaintiff has

properly failed to exhaust his remedies as to his denial of medical care claim. Plaintiff failed to properly appeal from his grievances.

Plaintiff's grievance dated August 11, 2003, states "every day every shift I try to find out if Dr. Hart has notified Harrison Eye Institute about scheduling my surgery". Id. Plaintiff's second grievance dated August 14, 2003, states "still no response about my much needed surgery on my eye. I speak to every nurse I send direct letters to Dr. Hart with them, and I'm sure your aware of my many request form as well. I am going blind." Id.

Plaintiff's grievances allegedly directed at Dr. Hart's actions do not allege a specific date of injury. In accordance with the Inmate Grievance Procedure policies in effect, Plaintiff was required to file a grievance within seven days of the date of the alleged incident of denial of medical care. It is not clear that plaintiff complied with this requirement. Furthermore, the grievances do not specify that Dr. Hart committed the alleged wrongdoing of denying medical care. At most, the grievances seem to allege that Dr. Hart had some duty to schedule care outside the facility for plaintiff.

Plaintiff does not claim to have omitted any grievance from the attachments to his Fourth Amended Complaint. Accordingly, from what is attached to the Fourth Amended Complaint, it is clear that Plaintiff's grievance was insufficient regarding the alleged failure to provide medical care.

Even if the foregoing grievance is considered sufficient for an initial grievance of excessive force against Paul Hart, which is not conceded, it is

clear that Plaintiff failed to appeal and therefore failed to exhaust his administrative remedies. An attempt by Plaintiff to cite the institution's failure to respond as a basis for showing that he need not have appealed his initial grievance is without basis. Even if the grievance procedure were a futile exercise, Plaintiff was nonetheless required to take all available steps which he clearly did not do. Woodford, supra; Johnson, supra. Inmates, such as Plaintiff, are educated by OCJ staff that they may appeal to the next higher level of administrative review if they fail to receive a response to a grievance when they believe a response is warranted. Despite having the opportunity to appeal, Plaintiff never did so and thereby failed to exhaust his available administrative remedies with respect to the subject of that grievance, i.e., failure by Dr. Hart to secure outside medical care for Plaintiff.

In sum, Plaintiff failed to exhaust his available administrative remedies by failing to allege a specific injury, and failing to properly appeal the initial grievances.

III. Summary judgment appropriate as to claims against Paul Hart

i. Summary judgment standard

In order to prevail on his motion for summary judgment, the defendant must show that plaintiff has no evidence to support his case or present affirmative evidence that plaintiff will be unable to prove his case at trial. Celotex Corp. v. Catrett, 477 U.S. 317, 322-23, 106 S.Ct 2548, 2553-54, 91 L.Ed.2d 265 (1986). If the defendant successfully negates an essential element

of plaintiff's case, the burden shifts to plaintiff to come forward with evidentiary material demonstrating a genuine issue of fact for trial. Id. The "mere existence of some alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no genuine issue of material fact." Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). A fact is "material" if it "might affect the outcome of the suit under the governing [substantive] law." Id. Accord Tipton v. Bergrohr GMBH-Siegen, 965 F.2d 994, 998 (11th Cir. 1992). Further, plaintiff must show more than the existence of a "metaphysical doubt" regarding the material facts, Matsushita Electric Industrial Co., Ltd. v. Zenith Radio Corp., 475 U.S. 574, 586, 106 S.Ct. 1348, 1356, 89 L.Ed.2d 538 (1986), and a "scintilla" of evidence or conclusory allegations is insufficient. Celotex Corp., 477 U.S. at 324 (quoting Fed.R.Civ.P. 56(e)). Plaintiff must either point to evidence in the record or present additional evidence sufficient to withstand a directed verdict motion at trial based on the alleged evidentiary deficiency. Celotex Corp., supra; Owen v. Wille, 117 F.3d 1235, 1236 (11th Cir. 1997) ("Rule 56(e) … requires the nonmoving party to go beyond the pleading and by h[is] own affidavits, or by the 'depositions, answers to interrogatories, and admissions on file,' designate 'specific facts showing that there is a genuine issue for trial.' "), cert. denied, 522 U.S. 1126 (1998) (quoting Celotex, 477 U.S. at 324, 106 S.Ct. at 2553 (quoting Fed.R.Civ.P 56c), (e))); Hammer v. Slater, 20 F.3d 1137 (11th Cir. 1994).

Evidence presented by plaintiff in opposition to the motion for summary judgment, and all reasonable factual inferences arising from it, must be viewed in the light most favorable to the plaintiff. Adickes v. S.H. Kress & Co., 398 U.S. 144, 157, 90 S.Ct. 1598, 1608, 26 L.Ed.2d 142 (1970); Jones v. Cannon, 174 F.3d 1271, 1282 (11th Cir. 1999). A motion for summary judgment should be granted if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law." Fed.R.Civ.P. 56; Celotex Corp. v. Catrett, 477 U.S. at 322, 106 S.Ct. at 2552.

ii. Plaintiff's medical history shows that his allegations against Defendant Paul Hart have no merit

Plaintiff has failed to show that the actions of Dr. Hart support a claim for deliberate indifference. In order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. Estelle v. Gamble, 429 U.S.97, 97 S.Ct. 285 (1976). When the need for treatment is obvious, medical care which is so cursory as to amount to no treatment at all may amount to deliberate indifference. Mandel v. Doe, 888 F.2d 783, 789 (11th Cir. 1989). Indifference can be manifested by prison doctors in taking the easier and less efficacious route in treating an inmate. Medical care that is so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness violates

the eighth amendment. Rogers v. Evans, 792 F.2d 1052, 1058 (11th Cir. 1986). Medical care so inappropriate as to evidence intentional maltreatment or a refusal to provide essential care violates the eighth amendment. Whether an instance of medical misdiagnosis resulting from deliberate indifference or negligence is a factual question requiring exploration by expert witnesses. Id.

Plaintiff has alleged in his complaint that Dr. Hart exercised deliberate indifference to Plaintiff's pre-diagnosed medical needs and health by failing to provide adequate medical care to him following his incarceration and being fully informed of those needs (Doc. 22 at ¶ 65). The record is totally devoid of any evidence to support plaintiff's allegation. The records received from OCJ show plaintiff's initial intake screening took place on May 7, 2003. At that time, plaintiff was noted to have reading glasses with him, and that he suffered from glaucoma that necessitated laser left eye surgery in 1985. Plaintiff presented with multiple complaints to Dr. Hart on June 19, 2003. He complained of glaucoma and that his eyes were becoming painful. Plaintiff was ordered to restart eye drops. The record noted that OCJ would call plaintiff's eye specialist Dr. Harrison to confim the type and dosage drops for glaucoma. The notation indicates "restart ASAP", and is signed by Dr. Hart. On August 7, 2003, a note from Dr. Hart directs OCJ schedule Plaintiff with Ophthalmology. An appointment was scheduled with outside physician Karen Stein. Furthermore, on November 4, 2003, the medical progress notes denote a conversation with Plaintiff regarding right eye glaucoma surgery wherein Plaintiff indicated that he

was not interested in pursuing right eye laser surgery at this time. He was instructed to continue self medication Pilocarpine eye drops. (See, Exhibit B attached hereto).

Plaintiff has alleged in his complaint that Dr. Hart intentionally did not prescribe the necessary medication to alleviate the buildup of inner ocular pressure associated with glaucoma (Doc. 22 at ¶ 65). The record is totally devoid of any evidence to support plaintiff's allegation. The records received from OCJ show medication notes for June 2003, July 1 through July 12, 2003, and September 2003, for COSOPT Ocumeter drops (drops used to treat glaucoma), ordered 1 drop in the left eye 2 times per day. The records note that the drops were given to the inmate. Charting for Dr. Hart in October 2003 and November 2003 regarding medication notes Pilocarpine (drops to treat glaucoma) to be administered in the right eye 3 times per day, and COSOPT Ocumeter Plus, to be administered in left eye 2 times per day were given to inmate. Similar notes through December 2003 indicate the inmate had, in his possession, the Pilocarpine drops. (See, Exhibit B attached hereto).

Plaintiff has further alleged that Dr. Hart refused to fulfill any of plaintiff's requests for follow-up care and/or outside care by a proper and available specialist promptly (Doc. 22 at ¶ 65). The record is totally devoid of any evidence to support plaintiff's allegation. The records received from OCJ show that on August 21, 2003, a consultation was ordered, reason for consultation

"c/o going blind". The consultation was requested of Karen Stein, MD. The notes show that Dr. Stein recommended prescription glasses, continued use of prescription Pilocarpine, and recommended right laser peripheral iridotomy, and right laser peripheral iridoplasty (laser surgeries to treat glaucoma). The records also show that a follow-up call was made by OCJ to Dr. Stein one day after Plaintiff's appointment on August 22, 2003, wherein inquiry was made concerning the immediacy of surgery. Dr. Stein informed OCJ medical staff that the surgery did not have to be done as long as Plaintiff used the eye drops as prescribed. (See, Exhibit B attached hereto).

Plaintiff has further alleged that Dr. Hart lacked the equipment to properly examine and/or monitor the disease and its progression or to treat beyond the provision of pain and/or inflammatory medications and/or prescribed eye drops to relieve the pressure (Doc. 22 at ¶ 65). The record is totally devoid of any evidence to support plaintiff's allegation. On the contrary, the records received from OCJ show that plaintiff refused care from the facility on May 8, 2003. The document signed by plaintiff states, "I choose to refuse to comply with the following recommended medical service" and Plaintiff writes, "this facility does not have the ability to measure my optic pressure nor treat me and I do not desire to waste their time or my money. Thank you anyway." Signed Russell T. Neal. (See, Exhibit B attached hereto).

Clearly plaintiff does not meet the standard to prove the actions of Dr. Hart support a claim for deliberate indifference and failure to provide medical care. The record is completely devoid of any evidence to support plaintiff's allegations against Dr. Hart. There are no genuine issues of material fact and Dr. Hart is entitled to judgment as a matter of law with regard to Plaintiff's claims against him.

iii. Plaintiff has failed to comply with Chapter 766, Florida Statutes

Plaintiff has failed to comply with Chapter 766's requirement to submit a verified written corroborating medical opinion within the statute of limitations, an error fatal to a claim of medical malpractice.

Section 766.203, Florida Statues governs the instant case. It states, in pertinent part:

> 766.203. Presuit investigation of medical negligence claims and defenses by prospective parties
>
> (1) Presuit investigation of medical negligence claims and defenses pursuant to this section and ss. 766.204-766.206 shall apply to all medical negligence, including dental negligence, claims and defenses. This shall include:
>
> (a) Rights of action under s. 768.19 and defenses thereto.
>
> (b) Rights of action involving the state or its agencies or subdivisions, or the officers, employees, or agents thereof, pursuant to s. 768.28 and defenses thereto.
>
> (2) Prior to issuing notification of intent to initiate medical malpractice litigation pursuant to s. 766.106, the claimant shall conduct an investigation to ascertain that there are reasonable grounds to believe that:

> (a) Any named defendant in the litigation was negligent in the care or treatment of the claimant; and
>
> (b) Such negligence resulted in injury to the claimant.
>
> Corroboration of reasonable grounds to initiate medical negligence litigation shall be provided by the claimant's submission of a verified written medical expert opinion from a medical expert as defined in s. 766.202(5), at the time the notice of intent to initiate litigation is mailed, which statement shall corroborate reasonable grounds to support the claim of medical negligence.

§ 766.203, Fla.Stat. (2002).

All subsequent versions of this statute contain the same requirement of a reasonable investigation on the part of the claimant which investigation includes a corroborating verified written medical expert opinion. See § 766.203, Fla.Stat. (2003)(2004)(2005)(2006)(2007). That opinion is to be served on all defendants with the notice of intent to initiate litigation. Id.

Section 95.11(4)(b), Florida Statutes provides as follows:

> (b) An action for medical malpractice shall be commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered, or should have been discovered with the exercise of due diligence; however in no event shall the action be commenced later than 4 years from the date of the incident or occurrence out of which the cause of action accrued, except that this 4-year period shall not bar an action brought on behalf of a minor on or before the child's eighth birthday…In those actions covered by this paragraph in which it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented the discovery of the injury the period of limitations is extended forward 2 years from the time that the injury is discovered or should have been discovered…

§ 95.11(4)(b), Fla.Stat. (2002).

All subsequent versions of this statute set forth the same limitations and repose standards. See § 95.11(4)(b), Fla.Stat. (2003) (2004) (2005) (2006) (2007).

Compliance with the pre-suit requirements in Chapter 766 is a condition precedent to maintaining a medical malpractice action. Florida Hosp. Waterman v. Stoll, 855 So.2d 251 (Fla. 5th DCA 2003); Weinstock v. Groth, 629 So.2d 835 (Fla. 1993). However, failure to comply with the exact sequence of events in Chapter 766 is not fatal to a claim of medical malpractice as long as the requirements of the statute are met within the statute of limitations. Hosptial Corp. of America v. Lindberg, 571 So.2d 446 (Fla. 1990); Kukral v. Merkas, 679 So.2d 278 (Fla. 1996).

In Kukral, the Florida Supreme Court explained the interplay between the pre-suit investigation procedure found in Chapter 766 and the statute of limitations governing actions for medical malpractice. 679 So.2d 278. There, the Court focused on the statutory pre-suit scheme and explained that the claimant is first required "to determine whether reasonable grounds exist to believe that someone acted negligently in the claimant's care or treatment and that this negligence caused the claimant's injury" and that "no medical negligence action shall be filed unless the attorney filing the action has made a reasonable investigation as permitted by the circumstances to determine that

there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant." Id. at 280.

"[I]n order to eliminate frivolous claims and defenses," the reasonable investigation precedes the filing of malpractice claims. Id. A "reasonable investigation" means that an attorney has reviewed the case against each and every potential defendant and has consulted with a medical expert and has obtained a written opinion from said expert." Id. Then, after the investigation is complete and before the claim is filed, the claimant is required to notify each prospective defendant of his intent to initiate litigation for medical negligence. Id. "Section 766.203(2) requires that the claim be corroborated by a 'verified written medical expert opinion' which must be furnished to the defendant." Id.

After the notice is received, 90 days are afforded to the defendant to conduct his own pre-suit investigation and the claimant is prohibited from filing his suit during that period. Id. A period during which the parties have the opportunity to conduct pre-suit discovery follows. Id. at 281. Then,

> After completion of presuit investigation and any informal discovery, and even before the actual filing of a medical negligence claim, "any party may file a motion in the circuit court requesting the court to determine whether the opposing party's claim or denial rests on a reasonable basis." If the court finds the claimant's notice of intent to initiate litigation is not in compliance with the reasonable investigation requirements of sections 766.201-.212, the court may dismiss the claim or impose other sanctions, including costs and attorney's fees.

Id. (internal citations omitted).

The Kukral Court had before it review of a dismissal where a medical malpractice claimant had failed to secure a verified written corroborating medical opinion prior to serving a notice of intent to initiate litigation. Id. at 279. The plaintiff followed up by serving an unverified opinion, then a verified opinion, and subsequently filed suit. Id. All acts were performed within the statute of limitations. Id. The defendant moved for a determination of whether the plaintiff had complied with the requirement that the verified opinion accompany the notice of intent. Id. Because the plaintiff had not complied with that statutory requirement, the complaint was dismissed. Id. Because the statute of limitations had run, the dismissal had the effect of barring the plaintiff's claim. Id.

On review, the Florida Supreme Court reaffirmed that "the medical malpractice statutory scheme must be interpreted liberally so as not to unduly restrict a Florida citizen's constitutionally guaranteed access to the courts, while at the same time carrying out the legislative policy of screening out frivolous lawsuits and defenses." Id. at 284. Thus, where a plaintiff complies with the pre-suit investigation requirements of Chapter 766 prior to filing suit and within the statutory limitations period, dismissal is inappropriate. Id.

Dismissal with prejudice *is*, however, appropriate where, as here, a plaintiff has failed to comply with the pre-suit requirements within the statute of limitations. Melanson v. Agravat, 675 So.2d 1032 (Fla. 1st DCA 1996)(failed to

respond to pre-suit discovery request); Okaloosa County v. Custer, 697 So.2d 1297 (Fla. 1st DCA 1997)(failed to provide corroborating opinion); Cohen v. West Boca Medical Center, Inc., 854 So.2d 276 (Fla. 4th DCA 2003)(no corroborating medical opinion); Shands Teaching Hosp. v. Miller, 642 So.2d 48 (Fla. 1st DCA 1994) (no corroborating medical opinion); Maguire v. Nichols, 712 So.2d 784 (Fla. 2d DCA 1998) (no corroborating medical opinion).

In the instant case, Plaintiff's alleged injury was caused during the time of incarceration at OCJ from April 30, 2003 through January 28, 2004 (Doc. 22 at ¶ 1). Plaintiff filed a Notice of Claim with the Department of Insurance on February 10, 2005. Within that Notice, Plaintiff does not allege a claim against Paul Hart (Id. Exhibit "C"). Plaintiff first alleges a claim against OCJ "Medical Staff" in his First Amended Complaint filed May 17, 2006 (Doc. 10). Plaintiff first alleges a claim against Defendant Dr. Hart in his Second Amended Complaint filed August 9, 2006 (Doc. 12). In advance of neither his First Amended Compliant, nor his Second Amended Complaint, did Plaintiff provide verified written corroborating medical opinion as required by the statutory scheme of 766.203, Florida Statutes. Plaintiff has failed to comply with the pre-suit requirements within the statute of limitations. Accordingly, Plaintiff should be prohibited from pursing his claim against Defendant Paul Hart.

* * * *

WHEREFORE, Plaintiff's claim against Defendant, Paul Hart, should be dismissed for Plaintiff's failure to exhaust administrative remedies, or in the alternative summary judgment should be granted in favor of Defendant, Paul Hart, in that Plaintiff has failed to allege any factual basis to show actions by Paul Hart constitute deliberate indifference, and Plaintiff has failed to comply with Chapter 766, Florida Statutes.

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been furnished to **RUSSELL T. NEAL, 213156**, Jefferson Correctional Institution, 1050 Big Joe Road, Monticello, FL 32344, and **Larry A. Matthews, Esq., and Jason B. Onacki, Esq.,** Bozeman, Jenkins & Matthews, P.A., 114 East Gregory Street, Pensacola, FL 32591-3105.

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